CADTH

CADTH REIMBURSEMENT REVIEW

Stakeholder Feedback on Draft Recommendation

TRALOKINUMAB (Adtralza)

(LEO Pharma Inc.)

Indication: Tralokinumab is indicated for the treatment of moderate-to-severe atopic dermatitis (AD) in adult patients whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable.

November 18, 2021

CADTH

CADTH Reimbursement Review Feedback on Draft Recommendation

Stakeholder information	
CADTH project number	SR0689
Brand name (generic)	Adtralza (tralokinumab)
Indication(s)	Tralokinumab is indicated for the treatment of moderate-to-severe atopic dermatitis (AD) in adult patients whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable. TRADENAME (tralokinumab) can be used with or without topical corticosteroids.
Organization	Origins Dermatology Centre – We represent a small, independent, Indigenous-led multidisciplinary grassroots organization based out of Saskatchewan that provides outreach services to northern and rural/remote communities in underserviced areas (Metis, First Nations and the general public).
Contact information[a]	Name: Dr. Rachel Asiniwasis

Stakeholder agreement with the draft recommendation		
1. Does the stakeholder agree with the committee's recommendation.	Yes	☐
	No	☒

To provide some context, as of 2021, we only have six full time dermatologists and two part time dermatologists (near retirement) servicing the entire province of over 1 million people in SK. Due to stress, burnout, and inability to sustain, we have lost four new graduates over the past couple of years to more well serviced centers. Given our region is underserviced in general, we often face more complex cases and higher loads of more severe patient presentations. Given that atopic dermatitis (AD) is deemed by ***Nature*** journal as 'the most common chronic inflammatory skin disease' (Weidinger et al., 2018), this is unsurprisingly one of the most common top presentations we are seeing.

Being in an underserviced area in Saskatchewan is just the tip of the iceberg, and the bigger picture must be looked at within the Canadian healthcare system. Due to long waiting lists, inadequate medical training, and a general lack of dermatologists, medical dermatology is a specialty facing what is described a crisis (Eedy, 2015; GAPP, 2018). In a Canadian context, according to the Eczema Society of Canada Quality of Life Survey Report for moderate to severe atopic dermatitis (2017), key concerns by national respondents include '**long wait times to see specialists, difficulty in obtaining dermatology referrals, geographic inequality in access to dermatologists and other specialists**.' (p. 2). Current systemic immunotherapies for moderate to severe AD and biologic therapies are vastly prescribed and managed by dermatologists, who are in very short supply.

As a full time dermatologist who experiences this reality on a daily basis and is already over-burdened and under-resourced, I can tell you that there are significant challenges and hurdles to prescribing traditional systemic immunosuppressants (such as MTX or CsA – None of which are FDA approved in Canada for AD.) Phototherapy is not available in the vast majority of non-urban areas, and thus, we cannot use that relatively safe modality to assist our patients and have to go directly to systemic treatment. Workup and safety monitoring for traditional systemic immunosuppressants require frequent and recurrent labwork, and other safety measures such as Chest X-Rays, infection tests and clinical monitoring amongst other considerations (ranging from instructing patients on vaccine washout considerations to ensuring they have age-appropriate cancer screening while on immunosuppressants, to managing secondary infection or bridging care for complications - such as Methotrexate-induced pulmonitis or transaminitis, or chasing down and following up on labwork abnormalities, or Cyclosporine induced hypertension or renal disease to only name a few…). **This is not easy to co-ordinate as a dermatologist in an underserviced area.** Many of my patients have no GP, or live in a remote area where

they can only access a locum GP on an intermittent basis, and can only intermittently access labwork. Often, labs are just not done because of this, or significantly delayed.

As another note, dupilumab itself has potential side effects which can be challenging to manage in underserviced areas. An example of this is ocular complications and facial dermatitis to the point of requiring discontinuation. We need safe options to try in case of this failure. Given this, we need another option such as Tralokinumab in our arsenal.

If traditional systemic immunosuppressant safety issues arise acutely, **the responsibility falls on the already overburdened dermatologist as the MRP (Most Responsible Physician) as primary prescriber, to manage/bridge care and monitor for potential complications of these drugs - which are not uncommon – when complications happen, patients will contact me directly.** In an underserviced area, not all patients can access labs or their Nurse Practitioner/GP on time, and all of these issues are further compounded by being in a pandemic. To be frank, if your committee is deciding on this being in a well serviced urban area, you clearly do not understand the challenges that underserviced physicians and non-urban centers face across Canada, and need to expand your consultation to those on such front lines. **As specialists and health care practitioners, we need safer options to help not just our patients but our own practices so that we don't continue to burn out and leave underserviced areas.**

With already established barriers identified, those that face significant health determinant burdens and access health care access issues may face even more difficulties in obtaining proper dermatologic care. In a Canadian context, limited published existing literature, health care practitioner experiences, and media (as referenced below), all point to concerns involving atopic dermatitis (eczema) and skin and soft tissue infections (often secondary to AD) in remote Indigenous communities, with a poorly documented "crisis" seen. Canadian literature suggests that one year prevalence of AD on reserve may be up to 16.5% (Forsey, 2014), although more information is needed. To further compound this, those with AD are also at increased baseline risk of developing secondary skin infections (eg. bacterial) when the disease is poorly controlled (Bieber, 2010; Weidinger et al., 2018). To avoid these complications, we need to treat the fundamental issue – which is the AD itself. A survey of remote health care practitioners in remote Saskatchewan Indigenous communities done by Asiniwasis et al. (2020) showed that the most commonly encountered dermatologic conditions include **atopic dermatitis (eczema) as #1, followed by impetigo (MRSA/non-MRSA)/skin infections.** Barriers reported by survey participants include cost, transportation, long wait times, travel barriers, level of comprehension with skin instructions/reading instructions, supply and access, proximity, access to healthy water sources, and cultural barriers. In the Canadian First Nations Regional Health Survey (2012) of the National Report on Youth and Children Living in First Nations Communities, AD was among the top three commonly reported chronic health conditions. AD was also identified as ***the most common*** reason for accessing care among majority of the youth, children and caregivers, despite noted barriers. Several barriers to accessing care were reported included concepts of: **"waiting list is too long", "felt health care provided was inadequate", "doctor or nurse not available in my area", and "service was not available in my area"** (First Nation Health Survey, 2010/2012). It is important to note that AD is a chronic disease, often persisting into adulthood.

In my opinion, it is unsafe and an insufficient use of the healthcare system for patients in underserviced areas who experience poor health care access to be prescribed systemic immunosuppressants such as Methotrexate or Cyclosporine if we do not have the resources to follow them properly and manage their complications. It's not just patients that need safer alternatives, it's also the limited availability of specialists under pressure. We face medicolegal concerns on this as well if we can't properly manage our patients or if an adverse event or outcome happens while they are on these meds. For whatever it means, here in Saskatchewan, we do not receive any subsidized overhead support, nursing, or call stipends. We are fully responsible for our own overhead costs, which run high, and staff training and especially during a pandemic. I can tell you that

continuing like this is not sustainable and I am losing confidence, considering moving to a better serviced area, and I'm not the only one. **The burden that traditional systemic immunosuppressants have placed on our site is by far the largest burden of all.** Given the safety and lack of need for labwork/imaging/infection testing, tralokinumab is an option that is strongly welcomed amongst those in my situation. **We need more options for moderate to severe AD. We need safer options. We need easier options.** Especially when moderate to severe and poorly controlled, AD is well documented to be associated with increased risk of wide-reaching physical, psychological, psychosocial and financial burdens including but not limited to anxiety, depression, attention difficulties, sleep loss, and even suicide (ESC, 2017). In the Eczema Society of Canada Quality of Life report for moderate to severe AD, **91% of respondents reported that 'their AD is not well controlled.'** 43% reported using '10 or more different treatments to manage their AD', and 29% reported 'having used 15 or more different treatments to manage their AD.' 87% report that their 'daily life is negatively impacted by their AD'. **Clearly, what we already have is not working.**

A lot of discussion exists around ECZTRA7 data. There are flaws in relying on this, including that t**his is a Belgium study with 99% Caucasian patients – this cannot be extrapolated to Canada's population and needs – especially given the vast areas of land and few and far between prescribers.** Cyclosporine is not recommended as a long term therapy in general for moderate to severe AD, and in fact, thought leaders and guidelines recommend to limit treatment to around 2 years due to the potential risk of side effects (the 'Consensus-based European guidelines for the treatment of atopic dermatitis in adults and children' state, word for word in their recommendation, '*Cessation of [Cyclosporine] therapy or switch to another systemic drug should be attempted after 2 years of therapy'*. Moderate to severe AD as a chronic disesease does not "go away" after 2 years. **We need more options for long-term therapy in this chronic disease in which there is no cure, with better safety profiles.** I know your committee has reviewed data in detail, however, one area of promise and potential for tralokinumab includes that skin infections requiring systemic treatment occurred with less frequency in the tralokinumab plus TCS group (0.7% vs. 5.8%). This shows promise for real-world studies on reducing the well documented burden on skin and soft tissue infections and needs to be considered, for example, in the crisis we are seeing in remote Canadian Indigenous communities with AD and skin infections.

Another major and promising highlight includes that in the Phase 3 long term extension trial ECZTEND as reported by Blauvelt et al. (2021), Tralokinumab demonstrates an efficacious and durable response in terms of improvement in mean EASI scores over two years from parent trials to ECZTEND long term data (as demonstrated in all groups including continuous, interrupted, and washout treatment periods). Given this information, it seems extremely promising for remote and underserviced areas and specialist prescribers alike. Approving tralokinumab would greatly benefit us all.

Expert committee consideration of the stakeholder input		
2. Does the recommendation demonstrate that the committee has considered the stakeholder input that your organization provided to CADTH?	Yes	☐
	No	☒
See #1 above		
Clarity of the draft recommendation		
3. Are the reasons for the recommendation clearly stated?	Yes	☐
	No	☒
CADTH needs to answer how dermatologists in underserviced areas are going to manage without safer and alternative options given that we already are facing major barriers. If you decline, we expect transparency beyond that of clinical trial data. We are here to advocate for our patients and colleagues.		
4. Have the implementation issues been clearly articulated and adequately addressed in the recommendation?	Yes	☐
	No	☒
	Yes	☐

5. If applicable, are the reimbursement conditions clearly stated and the rationale for the conditions provided in the recommendation?	No	☒
Remote and Indigenous populations facing health care disparities in an underserviced area have special considerations when managing CsA and Methotrexate. You also must consider the barriers clinicians face. We train for at least 12 years to become a specialist dermatologist, who are in short supply and our concerns need to be considered and respected as we work hard to help our patients.		

A. Assistance with Providing the Feedback		
1. Did you receive help from outside your clinician group to complete this submission?	No	☒
	Yes	☐
Independently written from our centre staff feedback (dermatologist RA, admin, nursing, and research assistant – None have any conflicts to declare except RA who has been in contact with sponsor).		
2. Did you receive help from outside your clincian group to collect or analyze any information used in this submission?	No	☒
	Yes	☐
N/A		
B. Previously Disclosed Conflict of Interest		
3. Were conflict of interest declarations provided in clinician group input that was submitted at the outset of the CADTH review and have those declarations remained unchanged? If no, please complete section C below.	No	☐
	Yes	☒
If yes, please list the clinicians who contributed input and whose declarations have not changed: • Clinician Rachel Asiniwasis No further conflicts to declare or changes in conflicts. The rest of team has not been in contact with sponsor, just myself who wrote this letter on our behalf.		

CADTH Reimbursement Review
Feedback on Draft Recommendation

Stakeholder information	
CADTH project number	SR0689
Brand name (generic)	tralokinumab
Indication(s)	Atopic dermatitis
Organization	Canadian Dermatology Association
Contact information[a]	Dr. Catherine McCuaig (President) Dr. Jason Rivers (Immediate Past President) [redacted] or [redacted]

Stakeholder agreement with the draft recommendation		
1. Does the stakeholder agree with the committee's recommendation.	Yes	☐
	No	☒

As stated in our submission of May 10, 2021, there are many unmet needs for an effective and safe therapy for atopic dermatitis. Although used for the treatment of severe cases of atopic dermatitis, there is no Health Canada approval for the use of immunosuppressive drugs such as prednisone, methotrexate, cyclosporine, and mycophenolate mofetil. The potential adverse effects of these medications are potentially devastating, and there is an additional, increased cost and burden to the Health Care system due to the need for regular monitoring, potential complications and pre-treatment investigations required. Further, none of these agents are safe for long term treatment of severe atopic dermatitis.
As only topical steroids and phototherapy are considered as relatively safe long term therapy, there is a need for new on label drugs for atopic dermatitis

Expert committee consideration of the stakeholder input		
2. Does the recommendation demonstrate that the committee has considered the stakeholder input that your organization provided to CADTH?	Yes	☐
	No	☒

Even if the disease is not controlled 100%, statistical improvements of tralokinumab vs placebo were clearly demonstrated in all three trials - ECZTRA 1, 2, and 3. EASI 75 scores reflective a clinically relevant improvement . Even EASI 50 is considered to be a successful outcome by many investigators. The EASI 75 scores seen in the tralokinumab studies speak to objective clinical improvements and these were 25%, 33.1% and 56.0% respectively. Non-significant reduction in pruritus in the ECZTRA 7 trial may have occurred due to a lack of statistical power to demonstrate a significant overall improvement in pruritus, which was seen in those individuals enrolled in the ECZTRA 1,2, and 3 clinical trials. This discrepancy may have arisen because the control group was permitted to use topical steroids in ECZTRA 7.

Clarity of the draft recommendation		
3. Are the reasons for the recommendation clearly stated?	Yes	☒
	No	☐

If not, please provide details regarding the information that requires clarification. Your response was clear.

4. Have the implementation issues been clearly articulated and adequately addressed in the recommendation?	Yes	☐
	No	☒

Although the current studies did not follow subjects for more than a year, there were no biologic or clinical signals to suggest a loss of efficacy with time. As well, there were no serious safety concerns identified.

There are no head-to-head studies comparing tralokinumab with dupilumab at this time and funding for such studies is unlikely to occur.

Up to two thirds of cases of severe atopic dermatitis are refractory to dupilumab treatment, and therefore, we require a safe and effective alternative. Although you mention the arrival of JAK inhibitors for the treatment of atopic dermatitis, there are several safety concerns due to their broader immunosuppressive potential and potential for drug interactions, that makes an anti-IL13 more appealing with regards to long term safety.

5. If applicable, are the reimbursement conditions clearly stated and the rationale for the conditions provided in the recommendation?	Yes	☒
	No	☐

If not, please provide details regarding the information that requires clarification.

[a] CADTH may contact this person if comments require clarification.

Appendix 2. Conflict of Interest Declarations for Clinician Groups

- To maintain the objectivity and credibility of the CADTH drug review programs, all participants in the drug review processes must disclose any real, potential, or perceived conflicts of interest.
- This conflict of interest declaration is required for participation. Declarations made do not negate or preclude the use of the feedback from patient groups and clinician groups.
- CADTH may contact your group with further questions, as needed.
- Please see the *Procedures for CADTH Drug Reimbursement Reviews* for further details.
- For conflict of interest declarations:
  - Please list any companies or organizations that have provided your group with financial payment over the past two years AND who may have direct or indirect interest in the drug under review.
  - Please note that declarations are required for each clinician that contributed to the input.
  - If your clinician group provided input at the outset of the review, only conflict of interest declarations that are new or require updating need to be reported in this form. For all others, please list the clinicians who provided input are unchanged
  - Please add more tables as needed (copy and paste).
  - All new and updated declarations must be included in a single document.

A. Assistance with Providing the Feedback		
2. Did you receive help from outside your clinician group to complete this submission?	No	☒
	Yes	☐
If yes, please detail the help and who provided it.		
3. Did you receive help from outside your clinician group to collect or analyze any information used in this submission?	No	☒
	Yes	☐
If yes, please detail the help and who provided it.		
B. Previously Disclosed Conflict of Interest		
4. Were conflict of interest declarations provided in clinician group input that was submitted at the outset of the CADTH review and have those declarations remained unchanged? If no, please complete section C below.	No	☒
	Yes	☐
If yes, please list the clinicians who contributed input and whose declarations have not changed:		

C. New or Updated Conflict of Interest Declarations

New or Updated Declaration for Clinician 1	
Name	Dr. Catherine C. McCuaig, FRCPC, FAAD
Position	President, Canadian Dermatology Association
Date	15-11-2021
☒	**I hereby certify** that I have the authority to disclose all relevant information with respect to any matter involving this clinician or clinician group with a company, organization, or entity that may place this clinician or clinician group in a real, potential, or perceived conflict of interest situation.
Conflict of Interest Declaration	
List any companies or organizations that have provided your group with financial payment over the past two years AND who may have direct or indirect interest in the drug under review.	

Company	Check Appropriate Dollar Range			
	$0 to 5,000	$5,001 to 10,000	$10,001 to 50,000	In Excess of $50,000
LEO Pharma	☐	☐	☐	☒
Sanofi	☐	☐	☐	☒
AbbVie	☐	☐	☐	☒
Pfizer	☐	☐	☐	☒

New or Updated Declaration for Clinician 2	
Name	Dr. Jason Rivers, FRCPC
Position	Immediate Past President, Canadian Dermatology Association
Date	15-11-2021
☒	**I hereby certify** that I have the authority to disclose all relevant information with respect to any matter involving this clinician or clinician group with a company, organization, or entity that may place this clinician or clinician group in a real, potential, or perceived conflict of interest situation.

Conflict of Interest Declaration

List any companies or organizations that have provided your group with financial payment over the past two years AND who may have direct or indirect interest in the drug under review.

Company	Check Appropriate Dollar Range			
	$0 to 5,000	$5,001 to 10,000	$10,001 to 50,000	In Excess of $50,000
LEO Pharma	☐	☐	☐	☒
Sanofi	☐	☐	☐	☒
AbbVie	☐	☐	☐	☒
Pfizer	☐	☐	☐	☒

CADTH

CADTH Reimbursement Review

Feedback on Draft Recommendation

Stakeholder information	
CADTH project number	SR0689
Name of the drug and Indication(s)	Adtralza (Tralokinumab) for the treatment of moderate-to-severe atopic dermatitis in adult patients whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable. Tralokinumab can be used with or without topical corticosteroids.
Organization Providing Feedback	FWG

1. Recommendation revisions Please indicate if the stakeholder requires the expert review committee to reconsider or clarify its recommendation.		
Request for Reconsideration	**Major revisions:** A change in recommendation **category** or patient **population** is requested	☐
	Minor revisions: A change in reimbursement **conditions** is requested	☐
No Request for Reconsideration	**Editorial revisions:** Clarifications in recommendation **text** are requested	☐
	No requested revisions	X

2. Change in recommendation category or conditions Complete this section if major or minor revisions are requested
Please identify the specific text from the recommendation and provide a rationale for requesting a change in recommendation.

3. Clarity of the recommendation Complete this section if editorial revisions are requested for the following elements
a) Recommendation rationale
Please provide details regarding the information that requires clarification.
b) Reimbursement conditions and related reasons
Please provide details regarding the information that requires clarification.

c) Implementation guidance
Please provide high-level details regarding the information that requires clarification. You can provide specific comments in the draft recommendation found in the next section. Additional implementation questions can be raised here.

Outstanding Implementation Issues

In the event of a positive draft recommendation, drug programs can request further implementation support from CADTH on topics that cannot be addressed in the reimbursement review (e.g., concerning other drugs, without sufficient evidence to support a recommendation, etc.). Note that outstanding implementation questions can also be posed to the expert committee in Feedback section 4c.

Algorithm and implementation questions
1. Please specify sequencing questions or issues that should be addressed by CADTH (oncology only)
1. 2.
2. Please specify other implementation questions or issues that should be addressed by CADTH
1. 2.
Support strategy
3. Do you have any preferences or suggestions on how CADTH should address these issues?
May include implementation advice panel, evidence review, provisional algorithm (oncology), etc.

CADTH

CADTH Reimbursement Review
Feedback on Draft Recommendation

Stakeholder information	
CADTH project number	SR0689
Brand name (generic)	Tralokinumab (Adtralza)
Indication(s)	For the treatment of moderate-to-severe atopic dermatitis in adult patients whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable. Tralokinumab can be used with or without topical corticosteroids.
Organization	Eczema Society of Canada
Contact information	Amanda Cresswell-Melville, Executive Director

Stakeholder agreement with the draft recommendation		
1. Does the stakeholder agree with the committee's recommendation?	Yes	☐
	No	☒

Please explain why the stakeholder agrees or disagrees with the draft recommendation. Whenever possible, please identify the specific text from the recommendation and rationale.

The Eczema Society of Canada (ESC) would like to raise the points below, following the negative recommendation for Adtralza/ tralokinumab:

- There are very few approved medications for moderate to severe atopic dermatitis, additional options are desperately needed by the patient community, and this new medication was deemed safe and effective by Health Canada
- AD is a complex disease, and it is common for patients living with moderate to severe atopic dermatitis to not respond to every medication they try, therefore additional options are required for patients
- As per ESC's patient input submission, tralokinumab was indeed 'clinically meaningful' for the patients who provided their input for the submissions
- Patient living with debilitating atopic dermatitis deserve choice in therapies
- The majority of patients we interviewed reported that tralokinumab was not only effective at reducing the frequency and intensity of flares but also at reducing the itch associated with their AD

"This drug changed my life. I have not had an open wound, infection, or even a skin eruption since about the first six months of this trial. I have only used topical ointment a handful of times since starting tralokinumab"

"Before my trial, I was 'existing', now I am a contributing member of my family and society. I hope that these drugs become covered by benefits for everyone (particularly when nothing else works)."

Expert committee consideration of the stakeholder input		
2. Does the recommendation demonstrate that the committee has considered the stakeholder input that your organization provided to CADTH?	Yes	☐
	No	☒

If not, what aspects are missing from the draft recommendation?

For the group of patients who live with uncontrolled moderate to severe AD, they may suffer immeasurably from the skin symptoms including blistering sores, infections, widespread crusting, flaking, and damaged skin. These patients deserve the chance to access new treatments like Adtralza/tralokinumab, and those patients who have had success with tralokinumab deserve continued access to this life-altering medication.

"Once I started experiencing an improvement from the medication, it has relieved my eczema symptoms ever since. I scratch minimally during sleep instead of all night long. Not having any open areas on me has improved my mindset and has made my life considerably better."

"The drug means that I am almost completely symptom free and [it] has allowed for a significant new freedom in being in the outdoors… the drug did an excellent job of managing the itching, redness and inflammation."

[a] CADTH may contact this person if comments require clarification.

Appendix 1. Conflict of Interest Declarations for Patient Groups

- To maintain the objectivity and credibility of the CADTH drug review programs, all participants in the drug review processes must disclose any real, potential, or perceived conflicts of interest.
- This conflict of interest declaration is required for participation. Declarations made do not negate or preclude the use of the feedback from patient groups and clinician groups.
- CADTH may contact your group with further questions, as needed.
- Please see the *Procedures for CADTH Drug Reimbursement Reviews* for further details.

A. Patient Group Information	
Name	Amanda Cresswell-Melville
Position	Executive Director, Eczema Society of Canada
Date	November 10, 2021
☒	I hereby certify that I have the authority to disclose all relevant information with respect to any matter involving this patient group with a company, organization, or entity that may place this patient group in a real, potential, or perceived conflict of interest situation.

B. Assistance with Providing Feedback		
1. Did you receive help from outside your patient group to complete your feedback?	No	☒
	Yes	☐
If yes, please detail the help and who provided it.		
2. Did you receive help from outside your patient group to collect or analyze any information used in your feedback?	No	☒
	Yes	☐
If yes, please detail the help and who provided it.		

C. Previously Disclosed Conflict of Interest		
1. Were conflict of interest declarations provided in patient group input that was submitted at the outset of the CADTH review and have those declarations remained unchanged? If no, please complete section D below.	No	☐
	Yes	☒

D. New or Updated Conflict of Interest Declaration

3. List any companies or organizations that have provided your group with financial payment over the past two years AND who may have direct or indirect interest in the drug under review.

Company	Check Appropriate Dollar Range			
	$0 to 5,000	**$5,001 to 10,000**	**$10,001 to 50,000**	**In Excess of $50,000**
Add company name	☐	☐	☐	☐
Add company name	☐	☐	☐	☐
Add or remove rows as required	☐	☐	☐	☐

Feedback on Draft Recommendation

Stakeholder information	
CADTH project number	SR0689-000
Brand name (generic)	Adtralza (tralokinumab)
Indication(s)	Tralokinumab is indicated for the treatment of moderate-to-severe atopic dermatitis (AD) in adult patients whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable. TRADENAME (tralokinumab) can be used with or without topical corticosteroids.
Organization	Eczéma Québec, CSPA
Contact information[a]	Name: Charlie Bouchard [redacted]

Stakeholder agreement with the draft recommendation		
1. Does the stakeholder agree with the committee's recommendation?	Yes	☐
	No	☒

"The CADTH Canadian Drug Expert Committee (CDEC) recommends that tralokinumab not be reimbursed for the treatment of moderate-to-severe atopic dermatitis in adult patients." (p.3)

Eczéma Québec and CSPA feel strongly that the recommendation committee failed to consider the limited number of options currently available to patients when coming to this conclusion.

"Patient input received for this review identified a need for additional treatments for patients whose AD is not controlled despite the use of existing treatments. Based on the evidence reviewed, CDEC could not confirm that tralokinumab would adequately meet this need due to the uncertain benefit of tralokinumab versus appropriate comparators." (p.3)

"[...] patients had accessed tralokinumab through a clinical trial and many felt it had significantly improved their pain, itching, discomfort, and the frequency of flares" (p.5)

Eczéma Québec and CSPA would like to reiterate the argument made in the initial submission highlighting the lack of treatment options currently available to patients suffering from moderate to severe atopic dermatitis in the current treatment landscape. Access to care and proper treatment is an issue that has been widely discussed over the years in the AD space.

In our initial submission, which was produced at a time where Dupixent was available, many unmet needs were identified from the survey investigation and interviews we conducted thus highlighting the remaining gap in effective and affordable treatment options available to patients.

Patients suffering from moderate to severe Atopic Dermatitis often struggle with extreme and constant disease burden and impact on HRQoL. With repeated failures in managing their AD within the traditional health care system, AD patients have a history of feeling dismissed and having to accept suboptimal solutions to address their concerns. It has been observed that people who have been struggling with continued flares and spikes of disease without periods of clear skin can become used to the suffering associated with the disease as if it were normal, lowering their expectations for new treatment options and being generally less optimistic about possible efficacy and safety of novel therapies. This should be considered when evaluating patient feedback on treatment for this population.

To clarify our stance in our initial submission, the question we posed to patients regarding their preferred method of administration was theoretical. We did not ask of them if they would prefer an injectable over moderate to severe symptoms of AD.

Additionally, given the great clinical heterogeneous nature of the disease, our organizations believe that introducing a new option, even though it has a similar mechanism of action, can benefit the patient by multiplying the paths in which they can access safe and effective treatments.

Just like in psoriasis, the immune system plays a role in AD. In the context of psoriasis, it's been established that patients need access to multiple treatment options even of some options have similar mechanisms of action. We believe that similar reasoning should be applied to the context of AD, especially in the context of life-cycle management of health technologies. The fact that only one targeted treatment is currently available should play a strong role in favor of rapidly increasing options for AD patients in Canada.

"Respondents also felt that new treatments should be covered by insurance or be affordable" (p.5)

Knowing that access to treatment is still limited and especially for sub-groups of the population, we do feel strongly that more safe and effective options are needed.

Expert committee consideration of the stakeholder input		
2. Does the recommendation demonstrate that the committee has considered the stakeholder input that your organization provided to CADTH?	Yes	☐
	No	☒

If not, what aspects are missing from the draft recommendation?

All patients quote we included in our initial submission have been evacuated from the final draft. We feel that these put in perspective the depth of individual patient suffering. While reviewing the tentative recommendation, we were uncertain that the committee appreciated the burden of living with the disease.

Clarity of the draft recommendation		
3. Are the reasons for the recommendation clearly stated?	Yes	☒
	No	☐

Despite the recommendation being clear, we feel like context is missing that would impact the reasoning.

4. Have the implementation issues been clearly articulated and adequately addressed in the recommendation?	Yes	☒
	No	☐

If not, please provide details regarding the information that requires clarification.

5. If applicable, are the reimbursement conditions clearly stated and the rationale for the conditions provided in the recommendation?	Yes	☒
	No	☐

If not, please provide details regarding the information that requires clarification.

[a] CADTH may contact this person if comments require clarification.

Appendix 1. Conflict of Interest Declarations for Patient Groups

- To maintain the objectivity and credibility of the CADTH drug review programs, all participants in the drug review processes must disclose any real, potential, or perceived conflicts of interest.
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- CADTH may contact your group with further questions, as needed.
- Please see the *Procedures for CADTH Drug Reimbursement Reviews* for further details.

Eczéma Québec

A. Patient Group Information	
Name	*Charlie Bouchard (Eczéma Québec)*
Position	*Director*
Date	*19-11-2021*
☒	I hereby certify that I have the authority to disclose all relevant information with respect to any matter involving this patient group with a company, organization, or entity that may place this patient group in a real, potential, or perceived conflict of interest situation.

B. Assistance with Providing Feedback		
1. Did you receive help from outside your patient group to complete your feedback?	No	☐
	Yes	☒

Eczéma Québec collaborated with the CSPA to put together the patient input submission and review of recommendation for the indication discussed.

We have met with the manufacturer to discuss the draft recommendation

All analysis and preparation of feedback was done independently by CSPA and Eczéma Québec alone

2. Did you receive help from outside your patient group to collect or analyze any information used in your feedback?	No	☐
	Yes	☒

Eczéma Québec collaborated with the CSPA to put together the patient input submission and review of recommendation for the indication discussed.

We have met with the manufacturer to discuss the draft recommendation

All analysis and preparation of feedback was done independently by CSPA and Eczéma Québec alone

C. Previously Disclosed Conflict of Interest		
1. Were conflict of interest declarations provided in patient group input that was submitted at the outset of the CADTH review and have those declarations remained unchanged? If no, please complete section D below.	No	☐
	Yes	☐

D. New or Updated Conflict of Interest Declaration

3. List any companies or organizations that have provided your group with financial payment over the past two years AND who may have direct or indirect interest in the drug under review.

Company	Check Appropriate Dollar Range			
	$0 to 5,000	$5,001 to 10,000	$10,001 to 50,000	In Excess of $50,000
Sanofi	☐	☐	☐	☒

AbbVie	☐	☐	☐	☒
LEO Pharma	☐	☐	☒	☐

CSPA

A. Patient Group Information	
Name	*Rachael Manion (CSPA)*
Position	*Executive Director*
Date	*19-11-2021*
☒	I hereby certify that I have the authority to disclose all relevant information with respect to any matter involving this patient group with a company, organization, or entity that may place this patient group in a real, potential, or perceived conflict of interest situation.

B. Assistance with Providing Feedback

4. Did you receive help from outside your patient group to complete your feedback?	No	☐
	Yes	☐

CSPA collaborated with Eczéma Québec to put together the patient input submission and review of recommendation for the indication discussed.

We have met with the manufacturer to discuss the draft recommendation.

All analysis and preparation of feedback was done independently by CSPA and Eczéma Québec alone.

5. Did you receive help from outside your patient group to collect or analyze any information used in your feedback?	No	☐
	Yes	☐

CSPA collaborated with Eczéma Québec to put together the patient input submission and review of recommendation for the indication discussed.

We have met with the manufacturer to discuss the draft recommendation.

All analysis and preparation of feedback was done independently by CSPA and Eczéma Québec alone.

C. Previously Disclosed Conflict of Interest

2. Were conflict of interest declarations provided in patient group input that was submitted at the outset of the CADTH review and have those declarations remained unchanged? If no, please complete section D below.	No	☒
	Yes	☐

D. New or Updated Conflict of Interest Declaration

6. List any companies or organizations that have provided your group with financial payment over the past two years AND who may have direct or indirect interest in the drug under review.

Company	**Check Appropriate Dollar Range**			
	$0 to 5,000	**$5,001 to 10,000**	**$10,001 to 50,000**	**In Excess of $50,000**
Pfizer	☐	☐	☐	☒
Sanofi	☐	☐	☐	☒
AbbVie	☐	☐	☐	☒

LEO Pharma	☐	☐	☒	☐